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This is the author's version of a work that was submitted/accepted for publication in the following source:

Windsor, Carol A., Douglas, Clint, & Harvey, Theresa (2011) Nursing and Competencies : A Natural Fit. The Politics of Skill/Competency Formation in Nursing. *Nursing Inquiry*, *18*(3). (In Press)

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Abstract

The last two decades have seen a significant restructuring of work across Australia and other industrialised economies, a critical part of which has been the appearance of competency based education and assessment. The competency movement is about creating a more flexible and mobile labour force to increase productivity and it does so by redefining work as a set of transferable or 'soft' generic skills that are transportable and are the possession of the individual. This paper sought to develop an analysis of competency based clinical assessment of nursing students across a bachelor of nursing degree course. This involved an examination of a total of 406 clinical assessment tools that covered the years 1992-2009 and the three years of a bachelor degree. Data analysis generated three analytical findings: the existence of a hierarchy of competencies that prioritises soft skills over intellectual and technical skills; the appearance of skills as personal qualities or individual attributes; and the absence of context in assessment. The paper argues that the convergence in nursing of soft skills and the professionalisation project reform has seen the former give legitimacy to the enduring invisibility and devaluation of nursing work.

Keywords: Competence, competency, soft skills, nursing, professionalisation.

Nursing and competencies: A natural fit

The politics of skill/competency formation in nursing

The last two decades have seen a significant restructuring of work across Australia and other industrialised economies, a critical part of which has been the appearance of competency based education and assessment. The competency movement is essentially about creating a more flexible and mobile labour force to increase competitiveness and productivity in response to international market pressure (Eldridge and Nisar 2006). How competencies ensure greater labour mobility is in the redefinition of work as a set of transferable skills. There has thus emerged a reframing of the concept of skill to include a range of 'soft' skills that are transportable and are the possession of the individual and hence, indistinguishable from personal attributes (Grugulis and Stoyanova 2010). As Payne (2000, 357) puts it, skills 'formerly understood…as complex social processes are now decontextualised and de-constructed, into finite, isolable 'competencies' to be located as the property of the individual, who then carried them, luggage-like, from job to job'. The result is workplace training and assessment that gives primacy to generic knowledge, attitudes, predispositions and behaviours over contextual work practices, with their expression in competency-based standards.

The point to be made here is that the reclassification of skills as soft skills has been politically and not theoretically driven (Griguli and Stoyanova 2010). It is indeed

difficult to see them as anything other than, what Sawchuk (2008) refers to as, 'floating signifiers' or, in other words, whatever suits the political moment. Thus it is of no surprise that the concepts of skill and competency, although ever difficult to define, are now considered more elusive and ambiguous (Payne 2000, 2009; Watson et al. 2002; Grigulis and Vincent 2009). The intent of this paper, however, is not to bring greater clarity to definitions of these terms but rather to develop a conceptual and analytical framework for understanding the theoretical and political implications of the expression of skills and competencies in student nurse clinical assessment tools.

As background, competencies entered Australian nursing in the early 1990s as part of a broader government and union supported work reform process. The Australian Nurse Registering Authorities Conference (ANRAC) initially developed competencies representing entry level performance for the registered nurse. In 1992, the ANRAC competencies became known as the ANCI competencies with the constitution of the ANC and subsequently were recognised as the Australian Nursing and Midwifery Council (ANMC) Competency Standards for the Registered Nurse. The ANMC Standards, last reviewed in 2004/2005, now come under the auspices of the newly formed Australian Health Practitioner Regulation Agency (APHRA). Although the interim period has also seen a proliferation of specialist competencies (Chiarella et al 2008), the focus of our research and analysis is on competencies and clinical preparation for registration as a nurse. First we turn to a contextual review of competency literature in nursing.

The context

Commentary and research on competency frameworks in nursing has, quite predictably, increased exponentially in recent years. Within this broad body of work, numbers of authors have pointed to a looseness of definition of competence and competency (Cowan et al 2005; Robb et al 2002: Reeves et al 2009; Watson et al 2002). Indeed, while the intent of nursing professional bodies generally has been to institute generic competencies derived from national standards, the translation of competencies in practice has resulted in a myriad of definitions and descriptors (Chiarella et al 2008). In Australia the ANMC, for example, defines competence as 'the combination of skills, knowledge, attitudes, values and abilities' that underpin performance. Yet, ANMC discourse dictates that competence be reduced first, to a set of 'competency units', or the stand alone functions to be performed by individuals, and second, to competency elements as sub-functions of 'units'. The latter recasts generic competencies as discrete individual behaviours and activities, the inference being that the generic in competencies has little to do with the standardisation of professional competence.

Others have noted the related difficulty of actually measuring performed competencies. Watson et al (2002), in reviewing the vast literature on clinical competence assessment in nursing, argue that assessment of competencies is problematic and not least because of the difficulty of determining what a competent level of performance might be in any practice area. A more recent and

extensive literature review of competency assessment in nursing also noted the absence of evidence in support of competency assessment tools and hence in support of the competency assessment approach as a whole (EdCaN 2008). This issue is not confined to nursing. Lurie et al (2009) systematically reviewed the body of research on the measurement of the six competencies underpinning the US medical accreditation system and found no evidence that competencies could be validly assessed.

A more general, if less voiced, criticism is that competency frameworks create a clear divide between theoretical and clinical education in nursing, one that may give support to those who see university education as superfluous to nursing practice (Chapman 1999; Watson et al 2002).

As is evident from the above, our analysis starts from the assumption that clinical nursing assessment tools and the competencies on which they are based are not value free. Rather, as Sawchuk (2008, 51) writes, 'The discourse of skill competency formation belies the fact that recognition, classification, regulation and the legitimacy and resources to shape activity in ways reflecting particular material interests represent deeply political questions.' In acknowledging the political nature of nursing competencies, this paper provides an analysis of competency based clinical assessment of nursing students across a bachelor of nursing degree course. The research purpose was to examine the function of

competencies in clinical nursing education and the implications of this framework for the nursing profession.

Sample

The sample for this research was drawn from an archive of nursing clinical assessments over a 17 year period from 1992–2009. The institution within which the School of Nursing operates is a large metropolitan university in Brisbane, Australia. For the purposes of analysis and to ensure a range of data, clinical assessments for each calendar year were drawn from each of three academic years of the bachelor degree. The documents were retrieved by a research assistant and were arbitrarily selected from archives for each academic year and for each calendar year. The method of storage of the documents deemed it difficult to retrieve equal numbers in either the academic or calendar year categories. The number of documents accessed was 180 for third year, 115 for second year and 111 for first year students, a total of 406 clinical assessments. Although numbers differed, the size of the samples representing each year enabled an extensive consideration of assessment structure and language from the start to completion of the degree course.

Ethical approval for this research was sought from the university human ethics committee. However research risk was deemed negligible and ethical approval not warranted.

Data analysis

The data were subjected to, in the first instance, a content analysis in light of the theoretical premises set out above. The intent was to portray both in terms of meaning and numerically the dominant representation of nursing skills as expressed in the language of the sampled documents. Thus the focus initially was on the identification of words in the clinical assessment documents as they depicted competence, reproduced competence in a particular form (as competencies) and structured the role of nurses. To achieve this intent, the final commentaries on clinical competence were situated in one of four categories: theory/knowledge, skills, personal attributes or no clear statement. To determine the relevant category the dominant descriptors within the assessor comments on each document were identified. Of the 406 documents, there was one reference to 'theory', 36 documents focused on knowledge, 70 were predominantly concerned with skill and 247 assessments were framed around personal attributes. Ultimately, both the overall structure of the documents, in terms of the organisation and wording of competency domains, and the clinical assessor comments were examined.

Analytical findings

In our analysis of competency assessments of nursing students a salient feature was the structure of the assessment forms to reflect a hierarchy of competencies which gave little focus to intellectual and technical skills. This is depicted in the

construction of the documents which, despite some variation, were organised around key generic competencies. For example, during the 1990s the generic domains were *interpersonal relationships, clinical decision making* and *professional development.* By early 2000 the domains had shifted to *professional and ethical practice, critical thinking and analysis, management of care* and *enabling.* At first sight the domains of clinical decision making and management of care alluded to skilled and situational work but in their discrete competency unit form appeared as a set of behaviours. Hence, in demonstrating management of care, the student *collects data, develops a plan of care, implements interventions, evaluates outcomes* and *maintains effective documentation.* These words notably resonate with the nursing process which has been criticised for its generic and theoretically deficient nature (Pearson et al 2005).

Yet, it was not as if the competency discourse in the assessment documents was uncontested. There is observable evidence of a tension between the generic areas and specific nursing skills. This appears in the form of a group of specific technical skills which were inserted into the document in the late 1990s as an additional assessment tool under the *Management of Care* competency. As indicated in Table One below, what is titled 'Essential Skills Assessment' includes skills such as complex wound care, measurement of vital signs and medication administration. Satisfactory demonstration of attainment was indicated by a tick against each skill.

[Insert Table 1 here]

By 2003, a larger grid, depicted in Table Two, incorporated skills such as accurate interpretation of cardiovascular status and medication administration and was situated at the end of the document following the final assessor comments.

[Insert Table 2 here]

The inclusion of the 'Essential Skills Assessment' tool is significant for three reasons. First, it indicates that the move to competency based assessment was not unmediated and thus not without resistance. Here was an acknowledgement that nursing skills and nursing knowledge were a neglected area in the assessment. Yet and second, the presentation of a list of skills to be ticked off as satisfactory or otherwise reflects a 'practical' approach which gives legitimacy to a lack of engagement with theory. As a result and third, the situation of these skills as an appendage rather than integral to competencies reinforced a hierarchy of knowledge which gave primacy to soft skills. We also see this hierarchy operating in assessor comments where, for example, a first year student is described as *a pleasure to work with and her extended level of knowledge has been an added bonus to the group.*

A second and related finding was the (re) labelling of skills as personal qualities or individual attributes. The following data in Table 3 is drawn from the assessor

comments recorded on the CATs over the period reflected in the data. These comments are to be understood as a product of a competency framework and not the erroneous words of assessors.

[Insert Table 3 here]

The data is presented above to indicate a *sameness* in the use of assessor language from the early 1990s to the end of the present decade and across the three years of the degree program. Although the use of the word 'skill' appeared more frequently in third year assessments and most often in explanations for less than satisfactory performance there was no less use of personal descriptors. The most often used terms across the sample were *confident and compassionate* and *energetic and motivated.* Indeed a good nurse is *courteous, conscientious* and *quiet.*

That the emphasis on soft skills is deemed a crucial political issue is the concern of those who argue a relationship between gender and the evaluation of skills. Many such arguments look to the merit of an appreciation of interpersonal or soft skills which often go unrecognised and unrewarded (Hochschild 1983; Warhurst and Nickson 2007; Grugulis and Vincent 2009; Findlay et al 2009; Williams and Connell 2010). What is proposed in this literature is that in women dominated work areas such 'skills' are readily dismissed as feminine or natural attributes (Bolton 2005; Findlay et al 2009; Lloyd and Payne 2009). Indeed, the neoclassic economic position is that because 'care work' is intrinsically rewarding

the ‘right type’ of carer will appropriately accept a lower wage (Heyes 2005). The counter argument is that soft skills compliment technical skills and contribute to productivity and improved outcomes and as such should carry monetary reward. This is the position of authors such as Bolton (2004) and Kosny and MacEachern (2010) who draw on Hochschild’s (1983) concept of ‘emotional labour’ in arguing that the social interactions required in service areas, nursing as one example, require a complex diversity of skills. Moreover, because such interactions take place in a context of managerial surveillance and productivity demands, effective interaction requires ‘high levels’ of skilled emotion work and is hard work (Bolton 2004).

Nonetheless, it is also the case that the increasing prominence of ‘soft skills’ afforded by the competency movement sits (too) comfortably with a salient discourse in nursing that seeks to reify ‘emotional work’ or ‘caring’ as the very essence of nursing practice. While this is not to detract from the importance of what constitutes emotional work in any occupation and what is indeed a fundamental feature of all work (Payne 2009), the pervasiveness of soft skills in nursing comes at the expense of making visible and of compensating the strong intellectual and technical skills and practices that are integral to nursing work. Within the hierarchy noted above, competency presents in the guise of virtues. Virtue equates with a general sense of goodness and is indeed considered a moral imperative. That nursing skills have hitherto been hidden behind the virtuous veil has been well explored (Nelson and Gordon 2006). As Gordon and Nelson (2006,

25) argue ‘the virtue script’ has long dominated the profession and largely as a default position in the absence of the ‘status and respect and self-esteem that flow from “discipline-specific cognitive-skills”’. Our argument is that nursing competency based clinical assessment functions to reproduce the predominant traditional, gendered virtue discourse in nursing. We see in the data above, for example, gendered assumptions in the assessment descriptors that are legitimised by the competency framework and that leave unaddressed the structural factors that produce and reproduce such assumptions (Grugulis and Vincent 2009). This is realised in giving primacy to the promotion and reproduction of desirable nursing behaviours over the recognition or measurement of skill attainment. Crucially, this outcome is not to be attributed to human error or a misinterpretation or misuse of competencies. On the contrary, if competencies are to be read as generic skills and standards then what must be expected in the demonstration of those skills is, to a greater or lesser extent, how workers feel, look and behave (Gruguluis et al 2004). The upshot is that the emphasis on ‘soft’ skills and the marginalisation of theoretical and technical knowledge upholds the traditional divisions between health care professions and sustains nursing as subservient.

An example of the enduring nature of the virtue agenda in nursing is the ascriptive criteria used in a report on nurses who accompanied Lucy Osburn to Australia in 1867-68, written by the matron of the Nightingale Training School, London. It reads as follows:

> Blundell is impulsive and rather noisy in her unreasonable moments, although of late she has improved…(and is)…less staid in manner than she probably would have been, had she not been thought a pretty woman.
> Miller is a very respectable woman and a good nurse, but is proud and peculiarly sensitive. The latter is a very trying and inconvenient failing to a superintendent…
> Mrs Chant is really an amiable woman, extremely kind, almost to a fault, to her patients.
> Haldane Turriff is a shrewd, clever Scotch woman, a good nurse and most thoroughly respectable, but her haughty spirit has at times been a source of much trouble to me (in MacDonnell 1970, 9).

The conclusion to be drawn here is that there has been a remarkable historical consistency in the construction of the nurse as constituting a set of social and personal characteristics. Walker and Holmes (2008, 115) add another dimension to this point in their historical exploration of nursing education textbooks wherein character consistently prevails over intellect and where the nurse embodies 'the hallmarks of idealised femininity' which deems the nurse largely invisible and certainly mute on matters that extend beyond being *enthusiastic* and *cheerful*.

In returning to the current era we see that nursing literature is replete with examples whereby personal attributes are redefined as skills. The concepts of knowing the patient (Tanner et al, 1993), presence (Parse 1998) and the therapeutic relationship (Peplau 1952, 1991; Forchuk and Brown 1989; Horvath

2005) are prominent examples. In a review of works on 'knowing the patient' in the mid 1990s, Radwin (1996, 1146) pointed out that while we have not as yet 'refined the components' of 'knowing', what we do know is that it 'actualizes a cherished value in nursing, treating the person as an individual'. Finfgeld-Connett (2006) started similarly in a review of writings on the 'vague and difficult to delineate' concept of 'presence' and soon thereafter concluded that the concept means 'sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances'. Furthermore, the therapeutic relationship is associated with (or constituent of) mutuality (Briant and Freshwater 1998), reciprocity (Marck 1990), person-centredness (McCormack 2004) and much more. In recounting a personal experience, O'Connell (2008, 141) notes that her relationship with a patient became therapeutic when she was 'authentically present' with the patient 'in a mutual and reciprocal alliance motivated by feelings of intense passion and empathy'. In turning to a 'meta-synthesis of caring', Finfgeld-Connett (2007, 202) finds that underpinning this concept is 'a nurse's professional maturity and moral foundations'. Very recently, Zambos (2010, 308) suggested that a systematic physical nursing assessment is simply a positivist distraction from what real nurses do in practice. Here, rather than seeking to emulate medicine, the focus of nursing should be on 'the encounter' between nurse and patient as this is 'the essence of caring'. Thus caring is the province of nurses (and by implication neither doctors nor anyone else). Finally, competence in spiritual care, van Leeuwen and Cusuller (2004, 245) wrote, means developing 'the right attitude' and this is to be achieved in education by encouraging 'reflection involving explicitly the student's full

personality'. Indeed, the aim of the literature review by these authors was to 'pull together the competencies nurses are supposed to possess for the provision of spiritual care' (2004, 234).

The soft skills expressed in the above examples contribute very little (if anything) to our understanding of what it is that nurses actually do and not least because emotional work labelled as skills is detached from any specific occupation or profession (Payne 2000). In fact the professional project that dominated nursing from the 1970s on was premised on the understanding of nursing skills as exclusive to the registered nurse role. The differentiation here is between skill as mundane (what most people can do) and skill as an ability that is confined within occupational boundaries. In other words, where skill is an ability it is one in relatively short supply (Payne 2009). But in nursing, generic soft skills substitute for intellectual and technical *nursing* knowledge and the result is a systematic undervaluation of nursing work. As such, the competency framework simply valorises an existing 'hierarchical knowledge politics' (Sawchuk 2008) which reproduces a form of professional exclusion or marginalisation. And as Bolton (2009) points out, work has material consequences and work that is defined by emotional labour, or soft skills, carries less status and attracts less recognition and material reward

A third analytical finding is that clinical assessments grounded in generic competencies exist without context. In other words, the generic nature of

competencies assumes a common set of capabilities regardless of situational factors. This means that where competence is seen to be generic it should carry the same action and effect regardless of context (Grugulis et al 2004). But while on the one hand competencies by their very nature individualise skill performance on the other hand teamwork, communication and nursing, by definition, are socially situated and mutually enacted. Just as knowledge is constructed through group processes and interactions, so too is competence in the application of that knowledge. As Willingham (2007, 26) argues in writing on critical thinking, an omnipresent competency in nursing, 'critical thinking…is not a skill. There is not a set of critical skills that can be acquired and deployed regardless of context'. This means that critical thinking is not about behaviour but rather about knowledge and that knowledge in its application is always contextual.

Some implications

The analytical findings articulated above have important implications for understanding the function of competencies and the competency framework in nursing work and nursing education. To return to our starting proposition, the presumption of a stronger linkage between the amorphous skill/competency discourse (Sawchuk 2008) and education is greater workplace flexibility. As argued elsewhere (Windsor 2007), the pursuit of micro-economic reform, as part of a broader productivity and competition agenda, has been a persuasive force in the health care sector over recent decades (Adams et al 2000; Bolton 2004; Productivity Commission 2005). Even though productivity in the health care

sector is difficult to measure, it is assumed that productivity gains are ensured if the cost of provision of services is lowered (Bryan and Rafferty 1999). This standard economic presumption has seen a concerted drive for greater efficiencies in health care through workplace flexibility. Indeed, this strategy has appeared with predictable consistency in government nursing and health workforce reviews over the last 15 years or more. In the US, the 1995 *Pew Health Professions Commission Report* on the regulation of the health care workforce (1995a) noted that regulation of practice should be organised around demonstrated competencies and not determined along clinical territorial lines. Published in the same year, the third report of the Pew Commission on health professions argued that 'professional training and practice should place more emphasis on developing the qualities of a superb generalist, capable of comprehensive care, as opposed to the current orientation toward specialisation . . . (and that) . . . this commitment to generalism must be part of every health profession' (1995a, 17). In the United Kingdom, *Making a Difference*, a government policy statement on the future of nursing and midwifery, proposed a 'new' and flexible nursing model a central feature of which is the introduction of the vocational roles of nursing and midwifery cadets, health care assistants and clinical support workers (DoH 1999). In short, the overriding emphasis in all these policies is on flexibility in training, education and skills.

We see similar trends in Australia. The 2002 Australian Government *National Review of Nursing Education* report refers to the 'unsustainability of current arrangements' and argues the need for a more 'appropriate' and sustainable skill

mix in the delivery of nursing care where 'the different skills of different groups can be best organised to ensure optimum outcomes for patients/clients (DEST, 2002, 13). Submissions to the inquiry from both academic and clinical institutions endorsed an increase in 'multi-skilling' (which translated means the increased use of lesser qualified health care workers). In overt terms and in reference to specialisation in nursing the report states that:

> Care should be taken to ensure that nursing does not lose the innate flexibility and adaptability that is its strength by pursuing increasing levels of sub-specialisation (DEST 2002, 86).

Finally, a letter from the Australian Health Workforce Ministerial Council to the Nursing and Midwifery Board of Australia in June 2010 concluded that, in relation to postgraduate midwifery courses, 'Ministers would prefer a competency based approach to training, which would consequently not require a reference to course duration' (AHWMC 2010). As Griguli and Stoyanova (2010, 4) so aptly note '…labour is not an asset to be grown but a liability to be minimized together with training and discretionary space, both expensive luxuries'.

It is though, in nursing, the processes occurred almost simultaneously: the move to the tertiary sector which opened the possibility of greater skill recognition and the shift to competency education and assessment. That the small window of promise of skill recognition has been closed is expressed in a shift in policy and nursing

discourse where care of the patient is no longer the exclusive province of registered nurses and where the concept of the professional nurse is replaced by flexibility, multi-skilling and teamwork. The incentive for this shift lies in the imperative to increase the productivity of the nursing labour force. An increase in the numbers of people cared for runs the risk of undermining quality of care and so the 'soft skills' agenda fulfils an important political and economic function. It allows for the lifting of productivity through the substitution of registered nurses by lesser qualified carers. Registered nurse work can be shifted first to enrolled nurses and then on to personal carers. As Palmer and Eveline (2010, 18) found, in exploring low pay in aged care, 'employers exploit the slipperiness of the notion of skill in care work'. Thus the problem (or the answer) lies in divorcing 'caring' from the full range of skills that are the territory of nursing. In this way soft skill competencies ensure the ongoing valorisation of nursing skills that underpin the flexibility and mobility of nursing labour.

The role of competencies is also critical because it has seen a shift away from educational institutions as the locus of control in learning towards the needs of the employing institutions (Sawchuk 2008), the health sector and the economy as a whole with the pre-eminent factor being productivity. The critical function of education is reduced to socialisation as the concept of academic competence is replaced by emotional competence. The motive for substituting education and training with skill and competency is:

> embedded in the need for productivity, but productivity of a profitable kind; it is embedded in the need for competitive national firms, but competition under certain auspices; it is embedded in the need to engage and reward people, but people constructed *as individuals* vis-à-vis a labour market; ultimately it is embedded in the need by one social group to control and appropriate the efforts of others (Sawchuk 2008, 53).

In other words, the profit driven agenda of greater competitiveness and productivity has been accompanied by the valorisation of those skills that can be readily manipulated as the labour market dictates. As nursing labour becomes more flexible then so the locus of control over nursing work shifts ever further to the market.

Concluding comments

State policies targeting individual skill/competency formation as a means of restructuring work in response to a more integrated economic world are common across developed nations and across industries. We can nonetheless see that the competency framework has implications that are peculiar to nursing because their origins sit outside the current work reform processes. These implications are grounded in the historical and structural features of the construction of nursing work. Thus, this paper has offered a reflection on the political function of competencies specific to nursing practice and the implications of the competency

framework for the nursing profession. What has been argued is that the appearance of competency and competencies in clinical nursing education, as political constructs, have crystallised the invisibility of the technical and intellectual skills that are integral to nursing work. The possibilities of the professional project in nursing of the late twentieth century appear to have been swept away by a movement that strengthens external control over nursing work. In other words, what is considered competent is ultimately determined by work organisations and labour markets and not by education facilities and educational and nursing theory. Whether or not the promise of the professionalisation movement was (and remains) an illusion, the overarching conclusion here is that the convergence in nursing of soft skills and professional reform has seen the former give legitimacy to the enduring invisibility and devaluation of nursing work.

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Table 1. Essential Skills Assessment Checklist from First Year Clinical Assessment Tool (2000)

2. ***CLINICAL DECISION MAKING***

***2.1** Uses a health assessment tool as the basis for the systematic collection of data

_____

_____

***2.2** Implements interventions/activities informed by the application of relevant theory and principles

_____

_____

***2.3** Provides a safe environment for the process of client care

_____

_____

***The student must have completed designated skills/activities in the following areas to support a satisfactory assessment (refer to performance indicators 1.2, 2.1, 2.2, 2.3, 3.4 in the CPAT guidelines).**

Health Assessment (general/focus)	**YES**	**NO**	**(Please circle)**
Transferring and Manual Handling	**YES**	**NO**	
Assisting with Activities of Daily Living	**YES**	**NO**	
Administering Oral and Topical Medication	**YES**	**NO**	

Table 2. Essential Skills Assessment Checklist from Third Year Clinical Assessment Tool (2009)

Essential skills assessments for criteria 3.1 and 3.3 are listed below. These must all be demonstrated satisfactorily as part of the assessment of these criteria. Depending on the circumstances, it is expected that 3rd year students may require minimal guidance, in demonstrating these skills.

Criteria		Satisfactorily demonstrated	Not satisfactorily demonstrated
3.1	Monitoring, accurate interpretation and reporting (as necessary) of a range of vital signs including cardiovascular, respiratory, neurological and psychosocial status.		
	Brief health assessment of individuals/groups		
	Comprehensive health assessment of individuals/groups		
3.2	Provision of physical and psychological care		
	Medication administration – oral and parenteral (including intravenous therapy, enteral feeding)		
	Simple/complex wound care		
	Manual/person handling in a variety of situations		
	Application of Standard Precautions in a variety of situations		

Table 3. Assessor Comments from Student Nurse Clinical Assessment Tools

First year		Second year		Third year	
1992–1999	**2000–2009**	**1992–1999**	**2000–2009**	**1992–1999**	**2000–2009**
… has a delightful smile that would light up any patient's day *… is a bright and enthusiastic student* *… has gained in both confidence and competence* *… has a quiet caring manner …* *… bright and cheerful manner was most welcome.*	*Conscientious, kind, caring, gentle – all the attributes for a fabulous nurse.* *… compassionate and considerate* *… bright and cheerful character* *… Always smiling* *… handled difficult situations with a maturity beyond her years*	*… has shown enthusiasm* *… a caring, confident student* *… shows skills and practice well beyond her level of training. She handles difficult personalities well and keeps her "cool" in all situations* *… intelligent and conscientious*	*… demonstrated a very keen attitude* *… is a bubbly caring student* *… pleasant when dealing with staff and clients* *… a warm, engaging and diligent student nurse …* *… has quietly achieved her clinical objectives …* *… has a bright polite manner …*	*… is cheerful and enthusiastic* *… quiet competent approach …* *… demonstrates an enthusiastic and motivated attitude* *… a natural and happy nature* *… excellent mature student* *… always acted in a professional manner* *… displays a caring and confident approach*	*… has demonstrated that she is a dedicated nurse* *… looks like a registered nurse … doing so in a more relaxed and confident manner that is unconsciously skilled* *… is a very caring, kind and competent nurse* *… is a pleasant caring and gentle nurse* *… quietly achieved skills …*